	CENT	US-09 15:12 ARTMENT OF HEALT LERS FOR MEDICAR	DC0547PM13501 H AND HUMAN SERVICES E & MEDICAID SERVICES	i	0f Lake City 8352125642 >>	B65 4	26 714 <i>4</i>	003/122
	POC	N OF CORRECTION	(X1) PROVIDER/SUPPLIER/CUA	- V-0-CO	ULT PLE CONSTRU		OMB I	RM APPROVO
	NAME OF	PROVIDER OR SUPPLIER	445259	B. WIN	-	·	COM	e survey
i	SUMME	T VIEW OF LAKE CITY					1	C
- 1		LAKE CITY	LLC		STY EET ADDRESS. CITY, STA 244 (NDUSTRIAL PARK D	TE SIDE	07	/30/2012
- 1	(X4) ID PREFIX	SUMMARY STAT	EMENT OF DEFICIENCIES	1	244 INDUSTRIAL PARK R	D CODE		
- 1	TAG	REGULATORY OF	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING MEDIA	J 10	#-WE CITY, TN 37769			
F			MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX	PROVIDER'S PLACE CORRECTIVE	W OF CORRECT	Dries	<del></del>
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1	r 400	INITIAL COMMENTS	— <del>——</del>	7	DEFK	SIENCY)	OPRIATE	DATE
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1	H	July 26, 27, and 30, 20 findings the facility was leopardy (a situation in	112. Based on survey	]				8/17/201
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	r a.	#J/19/27/19/19/19	* ************** / / / / / / / / / / /	' I			İ	
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	to	provide attempts and	or an elongate recurrent	- 1			· · · · · · · · · · · · · · · · · · ·	• • 1
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desicions apternant ending with an esteriek (\*) denotes a deficiency which the institution may be excused from correcting providing it is determined that young the date of survey whether or not a plan of correction is provided. For nursing homes, the findings stated above are disclosured to an early participation.

If deficiencies are client, an approved plan of correction are disclosured to the facility. If deficiencies are client, an approved plan of correction are disclosured to continued. 8/17/201Z

WV 12-	08-09 15:12	v u	mmit view Uf Lake City ② 004.	/122
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CEN	ERS FOR MEDICAR	H AND HUMAN SERVICES E & MEDICAID SERVICES	865 426 7144 p	
	ENT OF DEFICIENCIES IN OF CORRECTION			
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1		MACATION NUMBER.	OMB NO. O	970_/
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I THE OF	PROVIDER OR SUPPLIER	445259	B. WING ;	D
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			STREET ADDRESS CITY, STATE ZIP CODE	012
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			he facility will immediately inform	2012
1	received is required	io subseit a min.	1 he resident: consult with resident's	
			I hysician; and if known	
SScJ : //	B3.10(b)(11) NOTIFY NJURY/DECLINE/RO	OF CHANGES	I hysician; and if known, notify the interested family marking.	į
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īΑ	facility and r		1) an accident	- 1
į ce	pricing interest immediate the resident town, notify the resider	ely inform the resident	Vihich receives and resident	- 1
			potential for requiring physician	- 1
1 0	OIT MITTERS AND A STREET		itterrend for requiring physician	- 1
) ac	cident involving the re-	offs legal representative ember when there is an	ir-tervention; a significant change in	
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phy	raical, mental, or psych prioration in health, me	al for requiring physician change in the resident's	p: ychosocial status (i.e., a	- 1
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			psychosocial status in either life	- 1
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trans	equences, or to community; or a decision to	lance to adverse	treatment significantly (i.e., a need to discontinue and existing form of treatment due to adverse.	- [
the	ment); or a decision to sident from the facility	Vansfer or dis-1	treatment dead existing form of	1
\$483	rient; or a decision to sident from the facility .12(a),	S specified in	treatment due to adverse	1 -
			consequences, or to commence a new	j
The fa	acility must also as	1	form of treatment); or a decision to	1
and,	actify must also promp f known, the residents rested family member	By notify the resident	transfer or discharge the resident from	1
	PERSONAL SALARIL	·YSUIIGUIHUHAMA	the facility as specified in *483.12(a).	1
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1		1	is a change in room or roommate	
Marion o-		1	assignment as specified in	
~7(U2-99) <b>&gt;</b>	revious Versiene Obsolote	Event ASTOWPT:	*41-3.15(e)(2); or a change in resident	

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The facility's failure to notify the physician of current elopement attempts by Resident #3 author in an actual elopement and immediate opardy (a situation that is likely to cause ricus injury, harm, impairment, or death).  In immediate Jeopardy was effective on June 2012, through July 24, 2012.  Administrator and Director of Nursing were fied of the immediate Jeopardy on July 30, 2, at 12:38 p.m. in the Administrator's office, findings included:  Ew of facility policy, Guidelines for Assessing ange in a Resident's Condition Status, dated 2008 revealed, " Our facility shall promptly the Attanding Physician, of changes in the ent's medical/mental condition andor all Physician when there has been: a. An ent or incident involving the mit Instructions to notify the physician of	Continued From page 2 The facility must record and periodically update the address and phone number of the realdent's legal representative or interested family member.  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Findings included:  Car all facility policy, Guidelines for Assessing ange in a Resident's Condition Status, dated 2008 revealed, "Our facility shall promptly theAttanding Physician, of changes in the entire medical/mental condition and/or by theAttanding Physician or and Physician when there has been: a. 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The facility's failure to notify the physician of phaylors of seven sampled residents.  The facility will record and periodically update the address and phone number of the resident's expression of the resident's policy, medical record with the resident (#3) with identified elopement risk phaylors of seven sampled residents.  The facility will record and periodically update the address on price of the resident's expression of the resident's expre	EACH DEPTICIPATION OF DEPTICIPATES  RECULATORY OR LSO IDENTIFYING INFORMATION,  Continued From page 2  The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.  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2012-08-09 15:12 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8652125642 >> 865 426 7144 P 8 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTI "LE CONSTRUCTION OMB NO. 0838-0391 (AG) DATE SURVEY COMPLETED A BUILDING NAME OF PROVIDER OR SUPPLIER 445259 B. WING SUMMIT VIEW OF LAKE CITY, LLC STREET ADDRESS, CITY, STATE, ZP CODE 07/30/2012 2/4 NOUSTRIAL PARK RD SLAMARY STATEMENT OF DEFICIENCIES
(SACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) LARE CITY, TH 37769 (X4) ID PREFIX PROVIDERS PLAN OF CORRECTION
(EACH ODRAECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) TAG PREFIX (XS) COMPLETION DATE P 157 Continued From page 3 reviewed to identify events that changes in the resident's condition..." F 1571 require notification. Those items that Resident #3 was admitted to the facility on April are identified the facility will 10, 2012, with diagnoses including Dementia and irimediately inform the resident: Unspecified Bipolar Disorder. consult with resident's physician; and Medical record review of a hospital History and f known, notify the resident's legal Physical dated March 25, 2012, revealed. epresentative or an interested family "...admitted by neurosurgery services for subarachnoid hemorrhage...underwent aneurysm namber when there is an accident clipping...resulting in waxing mental status nvolving the resident which results in changes, psychosis...discharged again in stable q dry and has the potential for condition on 3-21-12...Daughter equiring physician intervention; a states...increased symptoms of agitation and denificant change in the resident's mental status changes...picking at things and has been talking about hurting...self. asked for sharp physical, mental, or psychosocial objects and a knife and talked about status compliance and results will be culting...wrist. Assessment and Plan:...concerns reported to the Interdisciplinary Care about suicidal ideations. Suicide precautions will I lan Team which consist of the Intector of Nurses, MDS Medical record review of an admission Minimum (cordinators, Social Services Data Set (MDS) dated April 17, 2012, revealed a Prirector, Environmental Services Brief Interview for Mental Status (BIMS) score I nector, Dietary Manager, Wound was seven (moderate mental impairment), felt down, dapressed, or hopeless nearly every day, Care Nurse and Activities Director; and rejected care one to three days. Continued whom will also review for review revealed the resident ambulated with e factiveness. The Director of Nurses supervision, was steady at all times with transfers will review results to ensure and ambulation, and required limited to extensive assistance with other activities of daily living. compliance. All in services will be auded to the new employee orientation Medical record review of a care plan dated April training to educate new employees on 23, 2012, revealed, "... Notify MD (Medical Doctor) if behavior interferes with functioning..." Notification Medical record review of a nurse's note dated June 17, 2012, at 2:00 p.m., revealed, "called to 4. Ithe Director of Nursing or Unit FORM CMS-2567(02-48) Previous Versienz Obsolete Supervisor will review the twenty-four Event ID: TOWF11

2012-0	8-09 15:13	b-a	it Alem C	1		<b>☑</b> 007/12
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i	resident's room com-		F 157	ndur reports daily t	·	. 7
i	and resident attach	en removed from window	1	acility immediatel	o ensure that ()	1e
į.	While staff was attach	ng to climb out redirected	:	esident 4	y miorms the	}
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į J	lune 17, 2012, at 9:30	O D INCOME DATED		TANKS TOURIST IN MINISTRA	French L	
j <b>"7</b>	Responded to CNA (	P.M., revealed, Certified Nursing Assistant)		A AMERICAN TO A LEGISTION OF	\~ L.	
16	alling out. Went to re	Sident's room to see CNA	ļ <del>"</del>	AND VOLUMENT RESIDENT	100-4 .T	_
I I I	chang resident to kee	p (resident) from falling out				
100	obeu mugam outo fi	p (resident) from falling out	1.5	-1 AMADARINI ALBUMA	TL	
140	nation acted ontare	attempted to climb out of	( h	our report will be be	The twenty- fo	)U <u>r</u>
m	indow, This nurse wa ade the same attended	s told the resident had	12	Coning Onalida	ought to the	
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			n	tification is being ac	me mai proper	
10 2	be aggressive and ag	kated or any delusions,	fis	tings of the	icressed. The	
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	The surveyor verified July 30, 2012, by ob- review, policy review,	tine corrective actions on Servation, medical record and interview.					
	Non-compliance cont	inues at a "D" level for					
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2012-08-09 15:13 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8652125642 >> 865 426 7144 P 12/89 CENTERS FOR MEDICARE & MEDICAID SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION <u>OMB NO. 0938-0391</u> DOS MULTIPLE CONSTRUCTION DENTIFICATION NUMBER: (X3) DATE SURVEY COMPLETED A. BUILDING. 445259 B. WING NAME OF PROVIDER OR SUPPLIER 07/30/2012 STREET ADDRESS, CITY, STATE, ZIP GODE 20: INCUSTRIAL PARK RD SUMMIT VIEW OF LAKE CITY, LLC LAKE CITY, TN 37769 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION BACH CONRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ш PREFIX COMPLETION DATE TAG DEFICIENCY) F 224 Continued From page 7 Crrective Action: 3. All staff was in-serviced on Abuse This REQUIREMENT is not met as evidenced by the Administrator Director of Herses or Unit Supervisor by Based on review of facility policy, medical record 8/14/2012. All clinical staff was in review, review of facility investigation, review of serviced on Neglect, Identification, Window alarm monitoring documentation, observation, and interview, the facility falled to Livestigation, Documentation, Patient prevent neglect for one resident (#3) with Assessment, Addressing identified elopement risk behaviors of seven Lecommendations Timely, and sampled residents. I diffication by 8/14/12 by the The facility's failure to prevent neglect for Lirector of Nurses, the Administrator Resident #3 with repeated elopement attempts and or Unit Supervisor. All clinical and actual elopement resulted in immediate start was also in serviced on the use of Jeopardy (a situation in which the provider's non-compliance with one or more requirements of the twenty-four hour report by the participation has caused, or is likely to cause Lirector of Nurses, the Administrator serious harm, injury, impairment, or death). and or Unit Supervisor by 8/14/2012. Tac Interdisciplinary Care Plan team The Administrator and Director of Nursing were which consist of the Director of notified of the immediate Jeopardy on July 30, 2012, at 12:38 p.m., in the Administrator's office. Ninses, MDS Coordinators, Social S avices Director, Environmental The immediate Jeopardy was effective on June Services Director, Dietary Manager, 17, 2012, through July 24, 2012. Wound Care Nurse and Activities The findings included: Review of facility policy. Preventing Resident Abuse, dated August 2008 revealed, "Our facility will not condone any form of resident abuse and will continually monitor our facility's policies, procedures...to assist in preventing abuse...Our abuse prevention/intervention program includes, but is not necessarily limited to... Assessing, care planning, and monitoring residents with needs and behaviors that may lead to conflict or neglect,

FORM CM9-2667(02-99) Provious Vorsions Obsolete

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If continuation sheet Page 8 of 84

CENTERS FOR MEDICARE & MEDICAD SERVICES  TAYADIANS OF DEPOINTING  ALCENIA  ALCENIA  TAYADIANS OF DEPOINTING  ALCENIA  AL	2012-08-09 15:13 DEPARTMENT OF HEALT CENTERS FOR MEDICAR	DC0547PM13501	nit View Of   <b>86</b> 5	52125642 >>	865 426 7144	
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F 224  Continued From page 8  Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issuesInvolving qualified psychiatriats and other mental health professionals to help ite staff managed elification or aggressive residentsIdentifying areas within the facility that may make abuse and/or neglect more likely to occurand monitoring these areas regulated as follure to provide goods and services to facility management immediatelyTo help with ecognition of incidents of abuse are provided Neglect to defined as follure to provide goods and services in ecosessary to avoid physician ham, mental anguish, or mental filineds  Medical record review of a hospital History and Physical dated March 25, 2012, revealed				1.1 - TO WALL PARK DIS	ZP CODE	180/2012
Assessing residents with signs and symptoms of behavior problems and developing and implementing care plans to address behavioral issuesInvolving qualified soldness behavioral issuesInvolving qualified specialists and other mental health professionals to help the staff manage difficult or aggressive residentsIdentifying areas within the facility that may make abuse analor neglect more likely to occurand monitoring these areas regularlyStriving to melintain adequate staffing on all stribs to ensure that the needs of each resident are metEncouraging all personnelto report any signs or suspected incidents of abuse to facility management immediatelyTo help with recognitions of abuse are provided geods and services angularly, or mental lifease"  Resident #3 was admitted to the facility on April 10, 2012, with desponses including Dementia and Unspecified sipolar Disorder.  Medical record review of a hospital History and Physical dated March 25, 2012, revealed, "admitted by neurosurgary services for subcracinoid hemorinageunderwent aneurysm clippingresulting in waxing mental status changes, spychosisdischarged again in stable condition on 3-21-12Daughter status changes, spychosisdischarged again in stable condition on 3-21-12Daughter status changes, spychosisdischarged again in stable condition on 3-21-12Daughter status changes, spychosisdischarged again in stable condition on 3-21-12Daughter with the facility on April 10, 2012, with degrees and stribe and talked about hurtingastiaasted for sharp objects and a knife and talked about suitingwristAssessment and Plantooncens about suitidal ideations, Suicide precautions will be initiated"	PREFIX (EACH DEFICIENCY TAG REGULATORY OR U	ATEMENT OF DUTICENCIES (MUST BE PRECEDED BY FULL SC EDENTIFYING INFORMATION)	PREPIX	PROVIDENTS PLAN [EACH CONRECTIVE A CROSS-REFERENCED T	OF CORRECTION ACTION SHOULD BE	COMPLETION
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Mi de (a)	shutsself in room cor" Medical recon alted May 5, 2012, at Puts chair under do: edical record review (	and sildes cheir against if review of a nurse's note s:00 p.m., revealed, or knob per night shift" of a physician's order vealed, "Change Haldol			-·' <u></u>		
Me Ma agi to r not "v hen mon date "c (res	dical record review of y 24, 2012, at 3:00 p. tated - Focused on g. nonitor." Medical recess dated May 28, 2012 vandering in haitway is 1 don't belong here.	f a nurse's note dated .m., revealed, "Severely oing homewill continue ord review of a nurse's 2; at 9:00 a.m., revealed, stating 'I want to leave exit seekingcontinue to I review of a nurse's note 0:50 p.m., revealed,		 			
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Medical record review of a Nurse Practitioner Progress note dated June 19, 2012, revealed, "Nursing staff notified of increased agitationappears extremely agitated and has delusions, combativeSchizoaffective disorder"  Medical record review of a physician's order dated June 19, 2012, revealed, "NP (Nurse Practitioner) to be notified if pt (patient) continues to be aggressive and agitated or any delusions, haltucinations."						

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July 30, 2012, at 12:15 p.m., in a conference	Inter	View with the Director	of Blumine /Posn		!   				

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	determine the duration of the duration of the supervision document July 13, 2012.  Medical record review July 14, 2012, reveale window plarm sounding window redirected barresident to bed covertoom." Medical recording July 14, 2012.	DON was unaware of the the supervision and unable to on of the one on one on the interior of the nurse's note on of a nurse's note dated ad, "@ 1 pm (1:00 p.m.) as resident with one leg out of with blanket and exited	F 2	24			
si re 20 se mi da " hot rev 6:1 ren on July	indowRN (Register thationwill confinue toord review of a nurse sking shaking door to onitor." Medical record ted July 17, 2012, at scontinuously askingmewill cont to monitiew of a nurse's note 5 p.m., revealed, " Enove screen in window patio. Unable to redinuscal record review of 19, 2012, at 2:30 a	attempt to climb out attempt to climb out ad Nurse) notified of to monitor." Medical e's note dated July 18, seled, "wanderingexit seled, "will cont to to review of a nurse's note 8:00 a.m., revealed, when am I going or." Medical record dated July 17, 2012, at bolt seeking, trying to v and climb over fence ect"			2		
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FRACE CONTINUED FROM PAGE 15  (resident) was out side, over at apartment	PREFIX	i I	PROMOTERIC DI	Promes	
(resident) was out side, over at apartment	1		ROSS-REFERENCED TO THE	MORTO 6E	COMPLETION
driving back to nursing home and seen (resident) running up the road to apartment complexsaw (resident) go into apartment #124the police came and helped get (resident) back to (secure unit)"  Medical record review of the Medication Administration Record dated July 2012 revealed the resident was administered Haidol 2 mg at 8:00 s.m. and 8:00 p.m., from July 1, 2012 through July 23, 2012. Continued review revealed administration of Haidol 1 mg at 12:00 p.m., was initiated July 24, 2012, twenty days following the first recommendation (of July 4, 2012) to increase the resident's medication, ten days after the resident's third elopement attempt (on July 14, 2012), and five days after the resident's elopement (on July 19, 2012).  Review of a facility investigation for a Notification of Unusual Occurrence Check List revealed,	F 224		DEFICRENCY	1	DATE

and Plan	OF CORRECTION	AND HUMAN SERVICES  & MEDICALD SERVICES  (X1) PROVIDER/SUPPLIER/CUA (IDENTIFICATION NUMBER:  445269	(X2) MI A. BUIL B. WIN	.D111+2	CONSTRUCTION	OMB N	M APPRO O, 0938 BURVEY LETEO
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Resident the state of the state	revealed the word "fall and included, "Local work out windowPal and elopes from facilities from hallway with dociosedInterdiscipling Review/Recommenda Window WorkingReview/Recommenda Window WorkingReview/Recommenda Proview review review review review of a "Monthly Vincenbriam" (secure unit in July 2 and included, "OK." Co documentation for the secure unit in July 2 eview of a facility investigation of a facility investigation of a facility investigation of a facility investigation of a facility investigation of a facility investigation	Review Form dated July 19, of Fall" Continued review of Fall" Continued review of Fall" Continued review of Fall Resident's room the to room of all Resident's room of the toroom F 22	4				

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window was open(resident) was gone, I rather apartment complex next door the police bring (bringing) (resident) brains and the police of th	n to	7 '				
bring (bringing) (resident) back to the nursing home in (police) car.	was					
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Review of a facility investigation and LPN #1					-	
statement dated July 19, 2012, revealed, "a	\$ t				- 1	
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was returned to the unit by a law enforcement	nt)				- 1	
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statement by CNA #1 dated July 19, 2012,	1 1	1				- 1
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asked if I could givea ride back (resident) hit mes. That's when I realized hymnes.		i			- 1	j
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#2) was at the form of the total and the tot	1 1	1				- 1
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knocked on the door and take care of this, She					1	1
law. Her husband called 911. The cops showed		,			- 1	- 1
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	comità ID.	102	H co	ontinuation sho	ot Page 18 c	f 84
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, ,	Continued From pag up and (RN #1) and walking overthe co nursing home*	e 18 (Maintenance Director) was p took (resident) over to the	F 224	<u>.                                    </u>	DEFICIENCY		-	
i i i i i	07/19/2012was in o window, and crawled o window, and crawled of resident)running do ust left the facility who note than 15 minutes. It not hear the alarm of the door was shut	will room, opened the put of window will the roadResident had in seen by the CNAnoThe LPN and the CNAs going off in the room due						· .
to ste that authors door	ation, and a fenced co- ough the resident's wi y 26, 2012, at 3:02 p.; ependently walked wi se's station and states ne. I love you. Can I g servation on July 27, 2 saled the resident asia r to the room was ope	July 26, 2012, at 2:07 ent asleep in bed, avealed the resident's st room from the exit door heat from the nurse's urtyard was visible indow. Observation on in, revealed the resident th a steady gait to the 1, "I wanta (want to) go o home with you?" 1012, at 10:25 a.m., sep on the bed and the			:	· I		
reve who Cont alam	view with the Mainten 2012, at 11:57 a.m., In aled alarms had been ow of the secure unit inued interview raveal as was tested monthly ked the evening the re	placed on every for at least two years, ed operation of the						

TATEM	NT OF SEMESTER	H AND HUMAN SERVICES  E & MEDICAID SERVICES				7144 FRINTI	N. UBUS
ND PLAN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/GLIA IDENTIFICATION NUMBER:	(DC2) M	A TIPLE	CONSTRUCTION		O. 0938.
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i	FOOT 700/pales the Re	entre pitti., itt a conference	[	. ;			
- 1	unaware the resident	had attempted to elope		[ [ ]			
1.	through the window o	f the resident's room prior to		] <u> </u>		j	
	the elopement on July	19, 2012.				Ţ	
- 11	Dierview with CNA 44		J	- 11		j	
įF	m. in a conference	on July 27, 2012, at 1:45 room, revealed CNA #1 had	1	11		i	•
	oft the facility for lunch	noom, revealed CNA#1 had as approximately 7:00		-   '	_	1	
	in, and on returning	from lunch observed the	- 1	[]	`,,		
n	System for of the laci	ity. Continued interview	- 1	11		- 1	
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ire	sident) go up the step	sThat shocked me that	-	1		1	ì
) va	sident) was that far er	nd nobody noticed"	1			Ī	ſ
Me	dical recent review =s	Abor	Į			ł	- 1
and	Interview with MDS	Coordinator #1 on July	i			1	j
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STIMENT VIEW OF LAKE CITY, LLC  STIMENT ADDRESS, CITY, STATE, 2P CODE 201 REPUSTRIAL ADDRESS  EACH OSE-CREAT OF DEFCHANCE FROM FROM FROM REQUIATION OR LSS DEMTEYMORPORATION)  F 224  Continued From page 21  # revealed M.D. #1 was the facility's Medical Director, and confirmed the recommendations for changes in the resident's antipsychotic medication was not communicated or autod on aimley, Continued Interview with M.D. #1  revealed M.D. #1, 2012.  Telephone Interview with a Psychiatric Nurse Practitioner (PMP) on July 30, 2012, at 4105 p.m. and in the presence of the DON, revealed the PSMP provides assessments of residents and stated. —1 take my assessments back to (mental health provider) and (mental health provider) follows up on communicating to facility what (my) recommendations are.  Interview with the DON on July 30, 2012, at 4105 p.m., in the DON's office, confirmed the facility registed to provide the care required by Resident #3. The DON stated, "We missed every opportunity"  Corrective actions which removed the immediacy of the jeopardy, included one on one supervision of the resident while installation of additional alams to windows on the secure unit was completed, assessment and care plan nevision for the resident and other reaidents at risk, and revision of policies and procedures and statif education regarding identification, investigation, and not provided the millional plant removed the immediacy of the jeopardy, included one on one supervision of the resident and other reaidents at risk, and revision of policies and procedures and statif education regarding identification, investigation, and not policies and procedures and statif education regarding identification, investigation, and not policies and procedures and statif education regarding identification, investigation,		OF CORRECTION	DENTIFICATION NUMBER:	(X2) M( A. BUIL	ALTIFLE DINC.	.11	OMB N	M AP O. 09 SURVI
Facultations of the construction of the constr	SUMMU	T VIEW OF LAKE CIT	Y, LLC	5		TTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTTT	07/	_
#1 regarding the resident's recurrent elopement attempts, Continued interview with M.D. #1 revealed M.D. #1 was the facility's Medical Director, and confirmed the recommendations for changes in the resident's antipsychotic medication was not communicated or acted on timely. Continued interview revealed timely administration of the increased dose of antipsychotic medication may have improved the resident's behavior and prevented the resident's colopement on July 19, 2012.  Telephone Interview with a Psychiatric Nurse olopement on July 19, 2012.  Telephone Interview with a Psychiatric Nurse Practitioner (PNP) on July 30, 2012, at 4:05 p.m., and in the presence of the DON, revealed the PNP provides assessments of residents and stated, " I take my assessments back to (mental health provider) assessments for evident shall provider) assessments for evident follows up on communicating to facility what (my) recommendations are:  Interview with the DON on July 30, 2012, at approximately 4:15 p.m., in the DON's office, confirmed the facility neglected to provide the care required by Resident #3. The DON stated, "We missed every opportunity"  Corrective scions which removed the immediacy of the jeopandy, included one on one supervision of the resident which installation of additional alarms to the windows on the secure unit was completed, assessment and care plan ravision for the resident and other residents at risk, and revision of policies and procedures and staff education regarding identification, investigation, and notification of unusual occurrences including abuse and/or neglect.	PREFIX	(EACH DEPICIONS REGULATORY OR I	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION)	PREPIX	$I^{-}I$	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCE) ACTION :	RECTION SHOULD BE	Cusa
	Interest of the company of the compa	attempts. Continued revealed M.D. #1 was attempts, and continued revealed M.D. #1 was Director, and continued in the residence of the antipsychotic medication of the antipsychotic medicates behavior as a comment on July 19 felephone interview was actioner (PNP) on the presence of NP provides assessment in the presence of NP provides assessment in the provider and (millioner and the facility near required by Reside Ve missed every operactive actions which it is to the windows or pleted, assessment a position of policies and praction regarding identification of unusual and/or neglect.	sident's recurrent elopement interview with M.D. #1 as the facility's Medical ned the recommendations for ent's antipsychotic communicated or acted on erview revealed timely increased dose of tion may have improved the nd prevented the resident's . 2012.  With a Psychiatric Nurse July 30, 2012, at 4:05 p.m., fithe DON, revealed the nents of residents and ressments back to (mental health provider) cating to facility what (my)  on July 30, 2012, at ., in the DON's office, glected to provide the nt #3, The DON stated, portunity"  removed the immediacy one on one supervision aliation of additional at the secure unit was and care plan revision for licents at risk, and ocedures and staff	F 224	T			

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NAME O	F PROVIDER OR SUPPLIER	445259	a. Wing	<u> </u>		C
	TIT VIEW OF LAKE CITY	пс	STR	GE ADDRESS, CITY, STATE		7/30/2012
(264) 113	SUMMARY STATE	EMENT OF DEFICIENCIES		AKE CITY, TN 37769		
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F 224	Continued From pag	e 22	F 224			<u> </u>
	The surveyor verified July 30, 2012, by obs review, policy review,	the corrective actions on ervation, medical record and interview.	j	,		
	Non-compliance continuitoring corrective	inues at a "D" level for actions through the facility's normance improvement s required to submit a plan				
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- 1	ALLEGATIONS/INDIVI	DUALS	- 1	; }.	ŀ	8/17/2012
- 1:	The facility must not en	ploy individuals who have	Th:	a facility will not em	miai.	
11	been found guilty of abi	ising, neglecting, or	( <del>11</del> 27)	lyiquais who have h	Com Samuel	
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6	ourt of law against an e	Molecus of actions by a	COT	State nurse aide regi cerning abuse, negle	stry	
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į TI	he facility must ensure	that all alleged violations	្រុងមេខាង	I'll Dy a court of less	200	1
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	7-99) Previous Versianz Obselet		J negre	ct, or abuse, includi		

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NAME OF	PROVIDER OR SUPPLIER	445259	B. WING			_ 1	C
SUMMIN	VIEW OF LAKE CITY				ADDRESS, CITY, STATE, ZIP PDUSTRIAL PARK RD CITY, TN 37769	CODE	30/2012 
PREFIX TAG		MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	PREFIX TAG		PROVIDER'S PLAN OF C (EAGH CORRECTIVE ACTI CROSS-REPERENCED TO TO DEFIGENCY	ON SHOULD BE	COMPLETION DATE
to the site of the	State survey and car  The facility must hav violations are thorous prevent further poten investigation is in pro investigation is in pro The results of all inve to the administrator o representative and to with State law (includi certification agency) v notdent, and if the alle appropriate corrective  This REQUIREMENT y: Sased on review of facility fai vestigate recurrent ele terview, the facility fai vestigate recurrent ele celopement for one n opement risk behavio sidents.  The facility's failure to in opement attempts by that elopement and in uation that is likely to cury, impairment, or de e Administrator and in e Administrator and in example of the correction of th	tification agency).  e evidence that all alleged thy investigated, and must that abuse while the gress.  estigations must be reported in his designated other officials in accordance of the officials in accordance of the officials in accordance of the officials in accordance of the officials in accordance of the officials in accordance of the officials in accordance of the officials in accordance of the officials of the officials of the officials of the officials of the officials of the officials of the officials officials officials officials officials officials officials of the officials of the officials officials of the officials officials officials of the officials officials of the officials officials of the officials offici	i i i i i i i i i i i i	the state of the s	mown source and minesident property are inediately to the administration and to other cordance with State law ordance with State law ordance with State law ordance with State law ordance with State survey and certainly will have evided violations are thoust gated, and must prestigated, and must prestigated, and must propress.  The state of all investigation of Nurses and to call in accordance with the state survey with the state survey with the state survey with the days of the incidence of the state survey or all the state survey with the state of the state survey with the state of the state survey or all the state of the incidence of the state survey with the state of the state survey or action of the incidence of the incidence of the state of the state of the incidence of the state of the incidence of the state of the incidence of the state of the incidence of the state of	sappropriation reported nistrator of officials in w through necluding to rtification dence that all roughly event further investigation ations must trator or the other h State law rvey and in 5 att, and if	

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- 1	THE COURT WASTES	o a.m., revealed, "wanders to go home" Medical		enty-four hour re	4.77 ICAID.	w the	
1	2012 at 0.55	rego home" Medical reg's note dated April 23,	/ Jah	enty-four hour re	TO DISID	ess	
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	co, 2012, revealed, "P	of the care plan deted April roblemSpecial Care Unit	1,17	ident and other re	esidents that m	av /	
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1 16	lolf Commissation in	is Will know: family, staff ferventions Special Care	C)kraa	lity Assurance M	mays to the dai	ily	
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l in	tenentias "Conti	nt free of hazards Assist	1 16 1	istered Nurse Suj Init Supervisor	pervisor and or	-	
th	e recidence sending a	nued review revealed no taff supervision while in	. 111	Init Supervisor.	On weekend a		
, ali	a residente toom auq	telf Supervision while in /or monitoring the window	11040	lays the unit supering	Triens and t	uct	
1		The state of the s	I ispo	nsible for review	Hyperap - 1	- 1.	
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rec	ord review at a more pa	or night shift" Medical	A H	e Social Service	ector of Nurse	s	- 1
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Yaket	May 31, 2012, at 10	\$0 p.m., revealed	marchi	n Onogen	a in the	1	j
/PA-2	NAs (Certified Nursing	Assistants) sald	£. 1	V Quality Assura	nce Meeting	1	Ì
	dent) had been exit-se	eking earlier, waa	TO CITTLE	e months to ensu	IG Complian	1	- 1
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	to patio and threateni anclosed courtyard) a nurse's note dated "(6A-6P) (6:00 a.m6 concentrate any lengt thing" Medical reco dated June 17, 2012, resident's room screen and resident attemption while staff was attemption	a.m., revealed, "went out ing to climb fence (fence ." Medical record review of June 10, 2012, revealed, :00 p.m.)unable to h of time on any one rd review of a nurse's note at 2:00 p.m., "called to n removed from window g to climb out redirected ting to fix window but	7) 7() 7() 7() 7() 7() 7()	met. The Administrator or the rector of Nurses will lead the ality Assurance Meeting each min to ensure that the items that are no reviewed are effective and to ntify any additional areas of icems that may be presented; or as still of the Quality Assurance eting going forward.	
re to ke or ou nu	surse's note dated Jun evealed, "Responded in resident's room to se sep (resident) from fail the ground, Resident it and attempted to a	e 17, 2012, at 9:30 p.m., to CNA calling out. Went to CNA holding resident to ling out of open window ant had pushed screen mb out of window. This			
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İ	reviewed and update	Comprehensive care plan  Lwith IDT (Interdisciplinary			<u> </u>		j	
i	Team) for quarterly (	CP (care plan) meeting"		1.11			}	
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- 1	plan regarding the rae	ident's recurrent elopement	j	'			- 1	
- f	altempts.	Contra recurrent elopement ;	1	- 11	1		1	
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- ;1	Medical record review a July 6, 2012, at 8:00 a	Of a minute.	- 1		ſ		Ī	
	July 6, 2012, at 8:00 a	or a nurses note dated	- 1		;		1	
-	n hallway Asking repet	of a nurse's note dated m., revealed, "wandering ively (repetitive) questions	ļ	;			- 1	
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115	eview of a nurse's note	monitor." Medical record dated July 11, 2012, at		1.	i.		f	
	nov p.m., revealed, "Re	dated July 11, 2012, at saident with agitation exit	[	i,	1		1	··
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m	oorredirection unsuc Onitor."	cestulwill cont to	- 1	11	}		ĺ	
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· TANALAD.	ow alarm sounding resourced back in w	Ident with one to and	- 1	Í :			İ	j
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winds	ow redirected back in v	Vitriou Holman						
winds	ow redirected back in vehicles to bed covered with	VindowHelped					- {	- 1
resid	ent to bed covered with	vindowHelped blanket and exited						
resid	ow redirected back in v ent to bed covered with Previous Versions Observe	windowHelped blanket and exited  Event Ex. Tawe 11						

HEALTH AND HUMAN SERVICES DICARE & MEDICAID SERVICES ES (XT) PROVIDERGUPPLIERCUA LIDENTIFICATION NUMBER:  445259  PPLIER E CITY, LLC  RRY STATEMENT OF DEFICIENCES LICIENCY MUST BE PRECEDED BY FULL FOR OR LSC IDENTIFYING INFORMATION)	A BUILDING  B. WING  8178	PLEC	25642 >> 865 42		D. 027 M APPI ), 1189
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STATEMEN	ERS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION	DC0547PM13501 AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/BUPPLER/CLIA (DENTIFICATION NUMBER:	(X2) MULT	irie ep	5642 >>	865 426	FORM OMB NO	1 APPRO 1 4988-0
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PREMITT ATEM OL FAKE CITA 2012-08-09 15:19 國 035/122 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8652125642 >> CENTERS FOR MEDICARE & MEDICAID SERVICES 865 426 7144 P 37/89 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION ראוועובט: עסונאוגעז. (X1) PROVIDER/SUPPLIER/CLIA FORM APPROVED CENTIFICATION NUMBER: OCO MULTI LLE CONSTRUCTION OMB NO. 0938-0391 A BUILDING (COMPLETED NAME OF PROVIDER OR SUPPLIER 445259 8, WING SUMMIT VIEW OF LAKE CITY, LLC TREE ADDRESS, CITY, STATE, ZIP CODE 201 INDUSTRIAL PARK RD 07/30/2012 (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) LIKE CITY, TN 37769 PROVIDER'S PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE ID PREFIX COMPLETION DATE TAG DEFICIENCY F 225! Continued From page 32: around in the yards over at the fairgrounds (an F 225 apartment complex). I asked if I could give...a ride back (resident) hit me 3 times. That's when ! realized it was going to take more than me to get (resident) back...(CNA #2) was at the front door ... to let some family members out .. The family members followed us over and asked what (resident) looked like... They told me to get in with them and they would drive me around to see if ! could find (resident). I happened to see a man across the street pointing towards an apartment...the woman that was with us said I'm a hurse let me take care of this. She knocked on the door and said she was calling the law, Her husband called 911. The cops showed up and (RN #1) and (Maintenance Director) was walking over...the cop took (resident) over to the nursing Review of the facility investigation dated July 25, 2012, revealed, "...Date of Alleged Event: 07/19/2012 .. was in own morn, opened the window, and crawled out of window (resident)...running down the road ...Resident had just left the facility when seen by the CNA in the fair grounds (apartment complex) no more than 15 minutes... The LPN and the CNAs did not hear the alarm going off in the room due to the door ... Jude asw Interview with CNA #1 on July 27, 2012, at 1:45 p.m., in a conference room, revealed CNA #1 had left the facility for lunch at approximately 7:00 p.m. and on returning from lunch observed the resident out of the facility. Continued interview revealed the resident was on the far side of the second street from the facility (not the location identified in the facility's investigation), and CNA

FORM CLIS-2587(GZ-99) Provious Versions Obtoloto

Event ID: TOWF(1

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If continuation shoot Page 33 of 84

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CONGLETION (X9)

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subgrachnold hemonthage...underwent sneutysm clipping...resulting in waxing mental status changes, psychosis...discharged again in stable condition on 3-21-12 ... Daughter states...increased symptoms of agitation and mental status changes...picking at things and has been talking about hurting...self...asked for sharp objects and a knife and talked about cutting...wrist...Assessment and Plan....concerns

Medical record review of a nurse's note dated

about suicidal ideations. Suicide precautions will

Director were in serviced by the Administrator by 8/14/2012 on Negrecat, Identification, Investigation, Documentation, Patient Assessment,

Nurses; MDS Coordinators, Social

Services Director, Environmental

Wound Care Nurse and Activities

Services Director, Dietary Manager,

Notification; and use of the 24 hour report for communication. The Feelity ID: TNC 102

if continuation shoot Page 36 of 64

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Fecord review of a hospital History and I dated Merch 25, 2012, revealed,	is REQUIREMENT is not met as evidenced  sed on medical record review and interview, facility falled to re-assess one resident with impact unsafe behaviors (#3) of seven  facility's failure to re-assess the recurrent all elopement and immediate Jeopardy (a. C.:  all elopement and immediate Jeopardy (a. C.:  all elopement, or death).  Impalment, or death).  Impalment, or death).  Impalment, or death).  Impalment, or death).  Impalment, or death).  In through July 24, 2012.  In through July 24, 2012.  In through July 24, 2012.  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The Administrator or Director of Nurses will lead the Quality Assurance Meeting each month to ensure that the items that are identified are updated in the resident's plan of cart. The Administrator or Director of Nurses will lead the Quality Assurance Meeting each month to ensure that the items that are being reviewed are effective and to identify

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F 280 Continued From page 53	DEPICIENCY)  COMPLETIO
about suicidal Hand	
about suicidal ideations. Suicide precautions will be initiated"	F 280 reviewed in the monthly Quality
	issurance Meeting to identify any
Medical record review of an admission Minimum Data Set (MDS) dated April 17 2010	1 sidents that need to be assessed or re
Data Set (MDS) dated April 17, 2012, revealed a	seessed. Also residents that have
Was seven (mental Status (BIMS) and	Changes that are identified that have
	changes that are identified during the
down, depressed, or hopeless nearly every day, and rejected care one to three days.	to reported to and the changes will
	to reported to and addressed by the
Medical record review of a nurse's note dated	interdisciplinary care plan team in the
	high risk meeting weekly so the
	residents care plan can be revised to
Darred Anyt so A	reflect the resident's current plan of
"wanders continuously, Wants to go home"	care. The Director of Nurses will
Medical management	
Medical record review of the care plan dated April 23, 2012, revealed, "ProblemSpecial Care Unit	4. Audits that are performed during
	the month by the Director of Nurses,
	the MDS coordinators, and the Social Selvices Director will by
(related to) safety Goals Will know: family, staff	
faces, room location interventions Special Care Unit :Keep environment free of homestal Care	presented at the monthly Quality
Unit :Keep environment free of hazardsAssist	***
1	Interdisciplinary Care Plan Team
Medical record review of a nurse's note dated April 23, 2012, at 8:00 p.m., revised	``¬'YALMUUSSISI OT THA TS:
April 23, 2012, at 8:00 p.m., revealed	1 7 10 10 10 10 10 10 10 10 10 10 10 10 10
CONTINUES MANAGEMENT	
aimlessly"	TO THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE PART OF THE
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Medical record review of a nurse's note dated May 3, 2012, at 9:00 p.m., revealed,	CANNUL ACTION OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF THE PARTY OF T
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door Medical record review of a nurse's note	
dated May 5, 2012, at 3:00 p.m. revealed, "Puts	Company Consultation Managers 1
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record review of a mile per night shift." Madical	The state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the state of the s
record review of a nurse's note dated May 24	month to ensure that the items that are identified are undated in the
record review of a nurse's note dated May 24,	idestrified are updated in the resident's plays of care, and are being assessed

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SUBMIT VIEW OF LAKE CITY, LLC  SUBMARY STATEMENT OF DEFICIENCIES  FAMOUS TRIAL PARK RD  LAKE CITY, TN 37769  TAG  FEGULATORY OR LSC DENTIFYING INFORMATION)  F 280  Continued From page 54  2012, at 3:00 p.m., revealed, "Severely agitated—formitor," Medical record review of a nurse's note of monitor," Medical record review of a nurse's note of monitor," Medical record review of a nurse's note of monitor," Medical record review of a nurse's note of dated May 29, 2012, at 10:50 p.m., revealed, (resident) had been exit-seeking earlier. Will  Medical record review of a nurse's note dated June 6, 2012, at 5:00 a.m., revealed, "went out monitor."  Medical record review of a nurse's note dated June 6, 2012, at 5:00 a.m., revealed, "went out monitor."  Medical record review of a nurse's note dated June 6, 2012, at 5:00 a.m., revealed, "went out to patio and threatening to climb fence"
(A)10 SUMMARY STATEMENT OF DEFICIENCES  EACH DEFICIENCY MUST BE PRECEDED BY FULL  TAG  F 280 Continued From page 54  2012, at 3:00 p.m., revealed, "Severely agitated - monitor." Medical record review of a nurse's note dated May 39, 2012, at 9:00 p.m., revealed, (resident) monitor." Medical record review of a nurse's note in contribute of monitor." Medical record review of a nurse's note dated May 31, 2012, at 10:50 p.m., revealed, (resident) had been exit-seeking earlier. Will Medical record review of a nurse's note dated May 31, 2012, at 10:50 p.m., revealed, (resident) had been exit-seeking earlier. Will Medical record review of a nurse's note dated May 31, 2012, at 9:00 a,m., revealed, (resident) had been exit-seeking earlier. Will Medical record review of a nurse's note dated May 31, 2012, at 9:00 a,m., revealed, (resident) had been exit-seeking earlier. Will Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record review of a nurse's note dated Medical record revie
F 280 Continued From page 54  2012, at 3:00 p.m., revealed, "Severely agitated from page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form page form pa
F 280 Continued From page 54  2012, at 3:00 p.m., revealed, "Severely agitated - monitor." Medical record review of a nurse's note dated May 29, 2012, at 9:00 a.m., revealed, "continue to monitor." Medical record review of a nurse's note dated May 31, 2012, at 10:50 p.m., revealed, (resident) had been exit-seeking earlier. Will Medical record review of a nurse's note dated May 31, 2012, at 9:00 a.m., revealed, (resident) had been exit-seeking earlier. Will Medical record review of a nurse's note dated to patio and truestening to climb fence"
F 280 Continued From page 54  2012, at 3:00 p.m., revealed, "Severely agitated - Focused on going homewill continue to dated May 29, 2012, at 9:00 a.m., revealed, here I don't belong here' exit seekingContinue to monitor." Medical record review of a nurse's note ateed May 31, 2012, at 10:50 p.m., revealed, (reskient) had been exit-seeking earlier. Will  Medical record review of a nurse's note dated to patio and threatening to climb fence"  Medical record review of a nurse's note dated to patio and threatening to climb fence"
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dated May 29, 2012, at 9:00 a.m., revealed, here I don't belong here' exit seekingContinue note dated May 31, 2012, at 10:50 p.m., revealed, (resident) had been exit-seeking earlier. Will Medical record feview of a nurse's monitor."  Medical record feview of a nurse's note dated to patio and threatening to climb fence"  Medical record review of a nurse's note dated to patio and threatening to climb fence"
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"CNAs (Certified Nursing Assistants) and (resident) had been exit-seeking earlier. Willi monitor."  Medical record review of a nurse's note dated to patio and truesmenting to climb fed; "went out Medical record review of a nurse's note dated to patio and truesmenting to climb fed; "went out Medical record review of a nurse's note"
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July 11, 2012, at 2:00 p.m., revealed, "Resident
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F 280 Continued From page 66  July 19, 2012, at 7:40 p.m., revealed, "(CNA #2) came running over to South Station where I was on a med (medication) cort., said (resident) was out side, over at exemite complex., (CNA #1) was on lunch, and came driving back to nursing home and seen (resident) point pute road to spartment complex., saw (resident) go into apartment extract had a fine drawn through it and (fresident) back to (secure unit)"  Review of a Notification of Unusual Occurrence (Trisylant2 Time: 8 p.m. Location; (the room the resident extract had a fine drawn through it and the room the resident was meved to after the elopement was identified) Original core plan Review of the original care plan revealed it had been updated but had not been updated with interventions related to attempts to elope and/or actual elopements.  Observation on July 28, 2012, at 3:02 p.m., reviewaled the resident ambutated to the nurse's station and stated, "I wanna (want to) go home. I love you. Can I go home with you?"  Medical record review of the resident's care plan and interview with MDS Coordinator's on July 27, 2012, at 2:05 p.m., in a conference from revealed the care plan was the resident's current care plan. Continued interview confirmed the edoriess the resident's recurrent attempts to elope and/or actual elopementy, included one on one superation of the jeopardy, included one on one superation.	<u> </u>		THE THE PERSON INFORMATION	PREFIX	· į	<b>1</b>	ACH CORRECTIVE ACTION	RRECTION	~~
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F 309 Continued from page 58  This REQUIREMENT is not met as evidenced by: Based on medical record review and interview, the facility falled to timely communicate recommendations for a change in an antipsychotic medication for one resident (#3) with recurrent unsafe behaviors of seven sampled residents.  The facility's fallure to ensure a change in an antipsychotic medication for recurrent unsafe behaviors was started timely for Resident #3 resulted in Immediate Jeopardy (a situation that is likely to cause serious harm, injury, impairment, or death).  The Immedidate Jeopardy was effective on June 17, 2012, through July 24, 2012.  The Administrator and Director of Nursing (DON) were notified of the Immediate Jeopardy on July 30, 2012, at 12:38 p.m., in the Administrator's office.  The findings included;  Resident #3 was admitted to the facility on April 10, 2012, with diagnoses including Dementia and Unspecified Bipolar Disorder.  Medical record review of a physician's order dated April 11, 2012, revealed, "Haldol 1 mg (milligrams) 3 tabs bid (an antipsychotic daily)." Medical record review of a physician's order dated May 40 and 5 are provised or a physician's order dated May 40 and 5 are provised or a physician's order dated May 40 are provised or a physician's order order dated May 40 are provised or a physician's order dated May 40 are provised or a physician's order order dated May 40 are provised or a physician's order order dated May 40 are provised or a physician's order order dated May 40 are provised order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order order	PROVIDETS PLAN OF CORRECTION EACH CORRECTIVE ACTION SHOULD BE CARDS-REFERENCED TO THE APPROPRIATE  CARDS-REFERENCED TO THE APPROPRIATE  CARDS-REFERENCED TO THE APPROPRIATE  CONTENTION  3. All clinical staff was in serviced on Neglect, Identification, Investigation, Documentation, Patient Assessment, Addressing Recommendations Timely, and Notification by 8/14/2012  by the Director of Nurses, the Idinical staff was also in serviced on  the use of the twenty-four hour report  ty the Director of Nurses, the Interdisciplinary Care Plan Team Which consist of the Director of Nurses, MDS Coordinators, Social Services Director, Dietary Manager, Wound Care Nurse and Activities Director were in serviced by the Asiministrator by 8/14/2012 on Neglect, Identification, Investigation, Decomentation, Patient Assessment, Notification; and use of the 24 hour report for communication. The twenty four hour report will be collected each day by the Unit Supervisor and reviewed to identify evenus that require notification. On the weekends and on holidays the Unit
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Revier staten reveal (7:40 p	partment complex nex (bringing) (resident) by in (police) car"  w of the facility investignent by (LPN #1) dated ed, "at approximately on	Jation and a July 19, 2012,		•		

2012-08-09 15:28 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8052125642 >> CENTERS FOR MEDICARE & MEDICAID SERVICES 865 426 7144 P 79/89 STATEMENT OF DEFICIENCIES FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (XZ) MULTIP .E CONSTRUCTION IDENTIFICATION NUMBER; OMB NO. 0938-0391 (XI) DATE SURVEY A GUILDING COMPLETED NAME OF PROVIDER OR SUPPLIER 445Z50 B. WING SUMMIT VIEW OF LAKE CITY, LLQ STITET ADDRESS, CITY, STATE, ZIP CODE 07/30/2012 204 INDUSTRIAL PARK RD SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX Lake City, th 37769 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY) TAG Ю PREFIX COMPLETION DATE TAG F 323 Continued From page 74 (electronic charting and electronic Medication F 823 Administration Record)...at the dask...(RN #1) enters the unit and says...has been told a resident has eloped from the unit. I ... was unaware of this,...and we both proceaded rapidly to (resident's) room...An alarm, which was inaudible standing immediately outside the closed door, was sounding...(resident) was returned to the unit by a law enforcement officer..." Review of the facility investigation and a statement by CNA #1 deted July 19, 2012, revealed, "While I was out on my lunch break I noticed (resident) running around in the yards over at the fairgrounds (an apartment complex), i asked if I could give...a ride back ...hit me s times. That's when I realized it was going to take more than me to get... (CNA #2) was at the front door...to let some family members out...The family members followed us over and asked what (resident) looked like... They told me to get in with them and they would drive me around to see if I could find (resident). I happened to see a man across the street pointing towards an apartment...the woman that was with us said I'm a nurse let me take care of this. She knocked on the door and said she was calling the law. Her husband called 911. The cops showed up and (RN #1) and (Maintenance Director) was walking over...the cop took (resident) over to the nursing Review of the facility investigation dated July 25, 2012, revealed, "... Date of Alleged Event: 07/19/2012...was in own room, opened the window, and crawled out of window (resident)...running down the read...Resident had just left the facility when seen by the CNA in the FORM CMS-2567(02-99) Provious Verbions Obtolete Event ID: TSWF11

Facility IC TV0102

if continuation sheet Page 75 of 84

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2012-08-09 15:29 **☑** 079/122 DEPARTMENT OF HEALTH AND HUMAN SERVICES DC0547PM13501 8652125642 >> CENTERS FOR MEDICARE & MEDICAID SERVICES 865 426 7144 P 81/89 STATEMENT OF DEPICHENCIES AND PLAN OF CORRECTION PRINTED: UD/US/2012 (X1) PROVIDER/SUPPLIER/CLIA FORM APPROVED (00) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: OMB NO. 0938-0391 A BUILDING (AG) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 445259 B. WING\_ SUMMIT VIEW OF LAKE CITY, LLC STY EET ADDRESS, CITY, STATE, ZIP CODE <u>07/30/2042</u> 234 INDUSTRIAL PARK RD (X4) ID PREFIX SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) LAKE CITY, TN 37769 TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PAEFIX COMPLETION TAG F 323 Continued From page 76 DEFICIENCY DATE Continued interview revealed operation of the F 323 alarms was tested monthly and the alarm was tested the evening the resident eloped (after the elopement). The Maintenance Director stated, ....If you were at the desk (you) could not hear it. You'd have to be close to it. (There is) no way to adjust the volume." Interview with the Maintenance Director on July 27, 2012, at 12:17 p.m., in a conference room, revealed the Maintenace Direcotor was unaware the resident had attempted to elope through the window of the resident's room prior to the alopement on July 19, Observation with the Maintenance Director on July 27, 2012, at 12:55 p.m., revealed the distance from the bottom of the resident's window to the ground of the parking lot was thirty-four inches. Continued observation revealed the time required to walk from outside the resident's window to the apartment from which the resident was returned to the facility was less than three minutes. Continued observation revealed the area outside the resident's window included the facility's parking lot adjoining a wooded area; a drainage ditch, and intersection of two public streets. Observation on July 30, 2012, at approximately 9:30 a.m., revealed an industrial park, a water treatment plant, and a bridge over a creek less than a minute from the facility driving at twenty miles per hour (the posted speed limit), Interview with the DON on July 27, 2012, at 1:37 p.m., in a conference room, revealed LPN#1, CNA #8, and CNA #4 were assigned to the secure unit at the time the resident eloped on July DRM CMS-2567(02-20) Provious Vamione Obsolute

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si si (ti two hee rou (re (re data Care	19, 2012. Continued facility's investigation from CNA #3 or CNA interview with CNA #1 p.m., in a conference left the facility for lund on a conference left the facility for lund on a conference left the facility for lund on a conference left the facility for lund on the facility for lund streat from the econd street from the econd street from the lated, "I noticed (reside of the road straight left) apartment where (to to three times right left, in the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the lated of the l	interview revealed the did not include statements #4.  on July 27, 2012, at 1:45 foom, revealed CNA #1 had at approximately 7:00 from lunch observed the lity. Continued interview ras on the fer side of the facility, and CNA #1 ident) right there on the across the street from resident) was athit me up the side of the more helpi got to the sed back and saw it that apartment. Saw isThat shocked me that id nobody noticed"	F 32	23		EFICHENCY)			
inter Inter Inter Inter Admi	onliator #7 on July 27 onference room, reveal resident's current care view confirmed the repean revised to address ment attempts and his view with the Director inistrator on July 27, 2 aled the DON had no attgations regarding electric continued interview of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy of the policy	plan. Continued plan. Continued sident's care plan had is the resident's tory of elopement. of Nursing and the 012, at 2:20 p.m., idditional							

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2012-08-09 15:30 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 84:52125642 >> 865 426 7144 P 84/89 CENTERS FOR MEDICARE & MEDICAID SERVICES PRINTED: 08/08/2012 STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROMOER/SUPPLIER/CLIA FORM APPROVED OMB NO. 0938-0391 (XZ) MULTIPLE CONSTRUCTION IDENTIFICATION NUMBER: COMPLETED A DUILDING 445259 8. WING NAME OF PROVIDER OR SUPPLIER STILEST ADDRESS, CITY, STATE, ZIP CODE SUMMIT VIEW OF LAKE CITY, LLC 07/30/2012 194 INDUSTRIAL PARK RD SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) LAKE CITY, TN 37769 (X4) ID PREFIX PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) TAG PREFIX TAG COMPLETION EATE F 323 Continued From page 79 Refer to F225-J. Substandard Quality of Care. F 323 Refer to F250-J. Substandard Quality of Care. Refer to F272-J. Refer to F280-J. Refer to F309-J, Substandard Quality of Care. C/O: #30197 F 490 483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING L=22 F 490 Requirement: he facility will be administered in a 8/17/2012 A facility must be administered in a manner that Pranner that enables it to use its enables it to use its resources effectively and efficiently to attain or maintain the highest 1550urces effectively and efficiently to practicable physical, mental, and psychosocial attain or maintain the highest well-being of each resident. I racticable physical, mental, and r sychosocial well-being of each This REQUIREMENT is not met as evidenced I #Sident Based on medical record review, facility policy Corrective Action: review, review of facility investigations, review of 3 All Clinical Staff was in serviced on window alarm monitoring documentation, Neglect, Identification, Investigation, observations and interviews, the facility failed to administer care in a manner to assess and notify Locumentation, Patient Assessment, the physician of recurrent unsafe behaviors, failed Addressing Recommendations to prevent neglect, failed to thoroughly investigate T.niely, and Notification by 8/14/2012 recurrent elopement attempts and/or an b" the Director of Nurses, the elopement, failed to provide required social services, failed to revise the care plan to address A liministrator and or the unit redurrent unsafe behavior, falled to timely Supervisor. All clinical staff was also communicate recommendations for an increase in serviced on the use of the twentyin an antipsychotic medication, failed to provide fear hour report by the Director of adequate supervision and/or security device to prevent elopement for one resident (Resident #3) N wses, the Administrator and or unit of seven sampled residents. supervisor by 8/14/2012. The In erdisciplinary Care Plan team The Administrator failed to ensure processes which consist of the Director of were in place to notify the physician, prevent PORM CMS-2567(02-59) Provious Versions Cosolete

Ø 083/122 2012-08-09 15:30 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8652125642 >> 865 426 7144 P 85/89 CENTERS FOR MEDICARE & MEDICAID SERVICES STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION FORM APPROVED (X1) PROVIDER/SUPPLIER/CLIA (XZ) MULTIPLE CONSTRUCTION OMB NO. 0938-0391 IDENTIFICATION NUMBER (XXX) DATE SURVEY COMPLETED A BUILDING 445259 B. WING. NAME OF PROVIDER OR SUPPLIER 07/30/2012 SUMMIT VIEW OF LAKE CITY, LLC STEET ADDRESS, CITY, STATE ZIP CODE 214 INDUSTRIAL PARK RD BLINIMARY STATEMENT OF DEFICIENCIES (EACH DEPICIENCY MUST BE PRECIDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (X4) ID PREFIX TAG LAKE CITY, TH 37769 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE PREFIX TAG COMPLETION DATE DEFICIENCY) F 490 | Continued From page 80 neglact, investigate, provide social services, Nurses, MDS Coordinators, Social revise the care plan, communicate medication Services Director, Environmental recommendations, and provide adequate Services Director, Dietary Manager, supervision and/or security devices for repeated Wound Care Nurse and Activities attempts to elope and the successful elopement by Resident #3 resulted in Immediate Jeopardy (a Director were in serviced by the situation that is likely to cause serious injury, Administrator by 8/14/2012 on harm, impalment, or death). veglect, Identification, Investigation, The Administrator and Director of Nursing (DON) Documentation, Patient Assessment, were notified of the immediate Jeopardy on July Votification; and use of the 24 hour 30, 2012, at 12:38 p.m., in the Administrator's eport for communication. The wenty-four hour report will be collected each day by the Unit The Immediate Jeopardy was effective June 17, 2012, through July 24, 2012. Supervisor and reviewed to identify vents that require notification. On The findings included: rekends the 24 hour reports will be Resident #3 removed a window screen and reviewed by the unit supervisor and attempted to alope from the facility on June 17. the results will be reviewed in the 2012, at 2:00 p.m., attempted to elope through a carly Quality Assurance Meeting on window on June 17, 2012, at 9:80 p.m., and the next business day. Systems that attempted to elope through a window on July 14, are identified to be deficient will be 2012, at 1:00 p.m. raviewed for effectiveness by the Interview with Minimum Data Set Coordinator Administrator and results will be (MDS Coordinator) #1 on July 27, 2012, at 2:05 reported to the Interdisciplinary Care p.m., in a conference room, confirmed the facility Fian Team which consist of the falled to revise the resident's care plan to address Lirector of Nurses, MDS recurrent attempts to clope and/or actual elopement Coordinators, Social Services Lirector, Environmental Services Interview with the DON and the Administrator on Lirector, Dietary Manager, Wound July 27, 2012, at 2:20 p.m., in the DON's office, Care Nurse and Activities Director; revealed no knowledge regarding the resident's attempts to elope two times on June 17, 2012. v hom will also review for

Continued interview revealed the DON had

e fectiveness. The Administrator will

cartinually monitor systems

2012-08-09 15:30 DC0547PM13501 DEPARTMENT OF HEALTH AND HUMAN SERVICES 8692125642 >> 865 426 7144 P 86/89 CENTERS FOR MEDICARE & MEDICARD SERVICES FORM APPROVED STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULT TLE CONSTRUCTION OMB NO. 0938-0391 EDENTIFICATION NUMBER: OG) DATE SURVEY COMPLETED a. Building B. WING NAME OF PROVIDER OR SUPPLIER 445259 07/30/2012 SUMMIT VIEW OF LAKE CITY, LLC STREET ADDRESS, CITY, STATE, ZIP CODE 2/4 INDUSTRIAL PARK RD SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION) LAKE CITY, TN 37769 (X4) ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEPOSENCY) Ш PREFIX COMPLETION TAG F 490 Continued From page 61 reviewed the twenty-four hour communication Associated with Neglect, book and spoken with nursing managers. The dentification, Investigation, DON stated, \*...all say they were unaware of Documentation, Patient Assessment, previous attempts to elope..." Continued Votification; and use of the 24 hour interview revealed no reports of elepement eport for communication for attempts had been made and the facility had no investigations into the resident's attempts to elope iffectiveness to prevent the presence prior to July 19, 2012. of deficient practices. Interview with the DON on July 30, 2012, at 12:15 . The Unit Supervisor will review the p.m., in a conference room, revealed the DON was unaware of the initiation of one on one twenty-four hour reports daily to supervision for Resident #3 on July 13, 2012, and ensure that notification is being unable to determine the duration of the one on Provided to the Physician and or One supervision. Lurse Practitioner on changes in a Telephone interview with the resident's physician r sident's status, and to ensure (Medical Doctor) (M.D. #1) on July 30, 2012, at compliance. On weekends and 12:20 p.m., in the administrator's office and in the holidays the twenty four hour report presence of the Director of Nursing (DON) and will be reviewed by the unit the Administrator, revealed M. D. #1 was unaware of the resident's attempts to elope from s: recrvisor and a copy will be the facility on June 17, 2012, and July 14, 2012. reviewed by the Director of Nurses on Continued interview confirmed the tle next business day. The twentyrecommendations for changes in the resident's feur hour report will be brought to the antipsychotic medication were not communicated or acted on in an effective, timely manner and daily Quality Assurance Meeting by timely administration of the increased dose of the Unit Supervisor. The Director of antipsychotic medication may have improved the Narses will perform three chart resident's behavior and prevented the resident's reviews a week to ensure compliance elopement on July 19, 2012. is a et for Neglect, Identification, Interview with the Social Service Director (SSD) In vestigation, Documentation, Patient on July 30, 2012, at 11:00 a.m., in a conference A sessment, Notification; and use of room, revealed the resident's risk for elopement the 24 hour report for communication. was discussed in a care plan meeting on July 3, The Administrator will review the 2012, and the resident's recurrent attempts to

elope were not discussed. Continued interview

Window Alarm System checks weekly as a new standard of practice going

2012-08-09 15:30 DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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